



Adult Addictions Inpatient Treatment
MEDICAL ASSESSMENT FORM

(Part I)



Name _____

HCN _____

Date of Birth _____

Address: _____ Telephone: _____

Physician's Name: _____

Address: _____

Telephone: _____ Fax: _____

This client is to be referred to the treatment centre, where he/she will participate in an inpatient treatment program designed to explore alcohol/drug dependency issues and/or problem gambling behavior.

Allergies: _____ ☐ **No Known**

Physical Examination: Height: _____ Weight: _____ Blood Pressure: _____

Brief Medical History (including psychiatric problems): _____

Stomach Issues: ☐ Yes ☐ No _____
Gout: ☐ Yes ☐ No _____
Liver Issues: ☐ Yes ☐ No _____
Hepatitis: ☐ Yes ☐ No _____
Seizures ☐ Yes ☐ No _____
Mental Health Issues: ☐ Yes ☐ No (i.e. Depression, Anxiety) _____

Is the client currently in a healthcare facility? ☐ Yes ☐ No If Yes:

Where: _____

Admission date: _____ Projected discharge date: _____

Reason for admission: _____

*** It is vital to forward discharge notes or consults.**

Examination (degree of abdominal hepatomegaly, spider nevi, tremors):

(Please include a copy of most recent blood work completed)

Could the client be pregnant? ☐ Yes ☐ No

Any physical limitations or special needs? ☐ Yes ☐ No If yes, please explain: _____

Physician/Nurse Practitioner's Name: _____ Date: DD/MONTH/YYYY

Physician/Nurse Practitioner's Signature: _____

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**Adult Addictions Inpatient Treatment
MEDICAL ASSESSMENT FORM
(Part II)**



Name _____

HCN _____

Date of Birth _____

Please identify any of the following that may apply to this client:

- | | | | |
|--|---|--|--|
| ☐ limited vision | ☐ limited hearing | ☐ learning disability | ☐ language barrier |
| ☐ intellectual disability | ☐ developmental disability | ☐ cognitive problems | ☐ language impairment |
| ☐ memory problems | ☐ speech impairment | ☐ other: _____ | |

Is the client able to walk, feed, dress, bathe and care for self? ☐ Yes ☐ No

If No, please explain: _____

Is physical nursing care required? ☐ Yes ☐ No

If yes, please explain: _____

Are you aware of any communicable conditions the client has which could affect the health of other residents or staff in a group setting? ☐ Yes ☐ No

If yes, please explain: _____

Has this client had the flu vaccine? ☐ Yes ☐ No

Do you suggest any medical follow-up while the client is at the treatment centre?

Problem: _____ _____ _____	Follow-Up: _____ _____ _____
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In your opinion, is the client able to participate in the treatment program (i.e., able to concentrate, take part in physical activity)? ☐ Yes ☐ No

In your opinion, is Nicotine Replacement Therapy safe for this client (i.e. gum, patch)? ☐ Yes ☐ No

Has the client began a smoking cessation or NRT program? ☐ Yes ☐ No

If yes, please explain: _____

CURRENT MEDICATIONS

Name	Dosage	Frequency	Reason for Use

Physician/Nurse Practitioner's Name: _____ Date: DD/MONTH/YYYY

Physician/Nurse Practitioner's Signature: _____



**Adult Addictions Inpatient Treatment
MEDICAL ASSESSMENT FORM
(Part III)**



Name _____

HCN _____

Date of Birth _____

Comments: _____

Is the client currently being prescribed Methadone as a treatment for addiction or pain? ☐ Yes ☐ No

If Yes, Dosage: _____ Length of time on that dose: _____

Prescribing Physician:

Name: _____ **Telephone:** _____

Fax Number: _____

Is the client willing to taper off Methadone, if necessary? ☐ Yes ☐ No

Signature of Client: _____

Date: _____ DD/MONTH/YYYY

Physician/Nurse Practitioner's Name: _____ Date: _____ DD/MONTH/YYYY

Physician/Nurse Practitioner's Signature: _____

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